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ABSTRACT

A cooperative partnership between the special education teacher and the occupational therapist (O.T.) is needed to serve the needs of the severely and profoundly retarded or otherwise severely handicapped. Child Find Programs are finding students in the 12 to 21 year age group who have never received any educational services but who may have higher potential than their lack of skills suggests. In a program geared toward normalization, the O.T. can help the child develop and maintain adequate posture, improve movement skills, and provide learning experiences. A recent Virginia survey indicated that teachers want more O.T. help with their students beyond the usual feeding and assistance with adaptive equipment. (DB)

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TEACHERS AND OCCUPATIONAL THERAPISTS:
A PARTNERSHIP FOR CHILDREN WITH SPECIAL NEEDS

Severely and Profoundly Retarded and Impaired

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TEACHERS AND OCCUPATIONAL THERAPISTS:

A PARTNERSHIP FOR CHILDREN WITH SPECIAL NEEDS

Severely and Profoundly Retarded and Impaired

The Severely and Profoundly Handicapped group of individuals does, at present, overwhelm many therapists and teachers. Until Public Law 94-142 we simply did not have to consider their needs. Institutions, Association for Retarded Citizens groups, and other small agencies conducted programs for some handicapped--the rest remained invisible at home. Suddenly, there are two to five classrooms of school children in this category in each special school with very little organized information and training for those of us trying to provide meaningfull experiences. Most of us scramble from one workshop or conference to another for help. There are signs now that the universities are beginning to recognize the need to cover this aspect of Special Education. The future looks brighter. Meanwhile we will continue to pool resources and learn from one another.

The immediate picture for these children may be quite different from the future one. Right now it is very important to consider that the Child Find programs are bringing us students in the 12-~~21~~ 24 year age group who have never been in programs. Some have not been seen by professionals including medical doctors since birth. The incidence of incorrect

placement may be too high. The lack of training in self help skills; lack of discipline; the absence of treatment for neuromuscular, visual, and auditory disorders, among others, can actually create a Severely and Profoundly Handicapped situation that looks real. The situation may or may not be irreversible. Being alert to these possibilities can result in upward mobility for a few and a higher training potential/quality of life for others. The clues are often so subtle that tests and checklists won't do. We need to be extremely sensitive to their reactions to conversations going on around them--their face and body language, etc. The Occupational Therapist can bring his medical model background to help sort through any number of sensory deficits that require further investigation. He or she can try to normalize postural and movement difficulties to look for real potential. Referrals for orthopedic and surgical evaluations will sometimes result in a child presenting a quite different picture.. Experience proves that with a period of adjustment and motor training, nonverbal communication systems can be developed by Speech Therapist/O.T. teams and, suddenly, we find a child who has something to say. This may be the first time in 15-20 years he has been able to act on his environment! The Child-Study Team can utilize all of this to put together the pieces of the puzzle. Within ten years this serious situation should not be a problem, due to infant and early childhood programs.

The best word to describe a good program for Severely and Profoundly Handicapped is normalization. This does not mean being normal. It means moving the individual toward normal developmental experiences of the life cycle. The O.T. wants to begin this process with:

I. Posture. For the obviously physically handicapped child this means finding and maintaining the correct furniture and equipment. Too often a chair is fitted and forgotten with no understanding of the fact that a very strong severely handicapped child will apply such stress to the equipment that within a short time it will not be effective without the correct adjustment. An understanding of neurophysiology is important to prevent that very piece from actually contributing to the pathology. Correct positioning and splinting can reduce and prevent further deformity. It can reduce primitive reflexes that interfere with visual attention required for the teachers' programs. Visual perception will be enhanced. Good postural conditions for the floppy child will reduce potential for scoliosis and sometimes free up arms and hands that have been too long employed in basic support. Stabilizing a child who is in constant motion of an athetoid type can improve communication skills, verbal and nonverbal, and feeding. Many times these things can be accomplished by a piece of foam, a velcro strap, a block of wood, etc.

II. Movement. The medical field and educators agree--movement is perception and learning. If we move pathologically, (ie. movement of the cerebral palsied child) learning is distorted and erroneous. A neurodevelopmental approach can sort and project the best movement potential of each child. On this foundation we can build comfort, efficiency of movement, and perceptual growth. The O.T. might first look at primitive reflexes that interfere with balance, visual motor tasks, and coordinating the two sides of the body. During play he might put the body through a more nearly normal pattern to reinforce neural pathways for normal experience. We find children, not obviously physically handicapped, who have such poor vestibular processing that they can develope actual deformities while simply trying to balance during walking. These same children often carry their heads at such an abnormally extended attitude that their eyes cannot serve them for good visual perception. Others may be in a flexion pattern that never allows them to reach out to investigate their world leaving them motorically and tactilely impoverished. Communication and feeding are movement experiences: the former, the basic social skill; the latter, a basic sustainance skill. If the O.T. can find and refine a manual pathway for communication; if the Speech Therapist can determine a language form for expression; if the teacher produces a developmental program for utilizing this new skill to a functional end; it seems that a little

miracle has occurred! O.T.'s and Speech Therapists using oral stimulation and neurodevelopmental techniques are finding ways to reduce drooling and tongue thrust and increase chewing and swallowing in Severely and Profoundly Handicapped of all ages. However; pathological positioning and movement can reduce these programs to shambles and must be monitored at all times for their neurological implications. If there are large feeding programs in a school the Speech Therapist/O.T.'s can probably serve best as supervisors--the actual one-to-one being accomplished by the teachers and aides. Here, again, we see the essential teamwork.

III. Experience. For many years O.T.'s have had success with some self abusive and self stimulating children by using bombardment of the tactile system. This is based on theory that these children cannot properly process tactile stimulation from their environmental experience. Such stimuli can cause reactions of pain, disorientation, and fear. Research in this area seems to be concentrated in institutional settings where there is much more control of therapy. The present movement of the Severely and Profoundly Handicapped person back into the community indicates a need for therapists/teachers/parents to pursue and research tactile therapy as treatment for the self abusive and self stimulating child.

Brown (2), Ford (6), and others talk about a need for more realistic functual approaches with this population. They suggest that we sometimes get stuck in developmental check-lists when the child has actually passed over items and is making an adjustment without them. They say that occasion-ally we need to pass over these items with them and move on. The O.T. should be able to help the teacher make descisions about these milestones--may even see where the child can do more physically than the teacher anticipates. Lana Ford (6) talks of the rule-of-three in being sure that the child has truly internalized a skill. This means he can perform the skill for three different people in three different settings, in response to three different language cues, and using three different instructional materials. Teachers can use the O.T. clinic as one of those 3 links in the chain. As we learn more about how to teach Severely and Profoundly Handicapped students at school we find ourselves moving quickly away from traditional and somewhat artificial instructional materials and into concrete items and natural environments. This means in-depth analysis of activities of daily living and the equipment required. There are now many published lists and prodedures but when we apply them to the real person, these lists often let us down. The O.T.'s strength should be in this type of individualized task analysis. Teachers, ask your O.T. for help here.

What is really happening at this time with the teacher/O.T. team in serving the Severely and Profoundly Handicapped? I recently took a written poll of twenty teachers of this population in four cities in Virginia. The individual responses were overwhelmingly similar: O.T. Department help is usually limited to feeding and adaptive equipment. Teachers want more O.T. time for more of their students. The frustration level is very high at this point. There are no clear cut answers. In Virginia where state guidelines recommend a caseload of sixteen clients for direct therapy, the O.T.'s are usually trying to see 25-35 children. Conditions are much better now than a few years ago. We hope for more progress. Meanwhile, therapists must learn to justify their needs to administrators, parents, and communities. Teacher support might make the difference. While we are working on that, teachers, keep asking your O.T. for help. There are few therapists who can turn down a teacher who shows a real interest in working as a teammate.

Perhaps the counterpoint to this presentation should be the teacher standing here telling how he can help us with these students. I extend the challenge as well as our thanks for our partnership.

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